proved. A few months later the man returned to have the knee operated on, as its condition prevented him from working. The swelling in the calf was laid freely open under antiseptic precautions and the sac was found to be very thin everywhere, except at its upper part, where it was constricted and communicated by a narrow channel with the upper and more deeply seated swelling. The communication with the joint could not be found. As much as possible of the sac was dissected out and a drainage tube left in. Made a good recovery.

Case II. Synovial Cyst in Popliteal Space. Patient, aged 51 years, commercial traveller. Complained of weakness in left knee. There was a swelling the size of a small Tangerine orange in lower part of popliteal space, slightly to inner side of median line. No pulsation, redness or tenderness. When the knee was flexed it disappeared, but became more prominent and very tense on extension. Palliative treatment failing, the swelling was laid open antiseptically. Sac very thin, but no communication with joint was found. As much as possible of cyst wall was scraped away. drainage tube inserted and leg fixed on a splint. Made a complete recovery.

Mr. Puzey considers that if the cases are seen early palliative measures should certainly be tried, but unfortunately usually fail. He thinks that subcutaneous rupture, either by force or a tenotomy knife might be successful; but prefers free incision and drainage if strict Listerian principles can be employed.—*Lancet*, Dec. 4, 1886.

H. H. TAYLOR (London).

IV. Further Cases of Plastic by Fresh Pedicled Flaps from Distant Parts of the Body. By Prof. H. MAAS (! Würzburg). As an addition to like cases previously reported by M. [v. ANNALS, 1885, June, p. 572] three new ones are here given in which success was attained by the above method.

In the first case there was extensive ulceration on the outer side of the left leg, which had withstood all other attempts at cure. The trouble originated in a large phlegmon from a contusion over a year previously. The depressed atonic sore was surrounded by a wide cicatricial zone. The ulcerated surface was cut around and prepared off, leaving a 12 x 4 ctm. defect. To avoid oozing into the dressing as

far as possible, constriction was not applied. The next step consisted in forming a flap from the inside of the right leg. This was 16 by 6 to 7 ctm. It included fascia and was taken longitudinally with its base at the middle of the leg. The large saphenous vein had to be tied. Each foot and lower part of leg was put up in plaster and then so placed that the slightly flexed left extremity lay on the extended and slightly rolled outward left. The two plaster bandages were then united together by a third. In this way the flap could by moderate twisting be laid in the defect. Finally, the free flap edges were carefully sutured in place, the wound surface covered with a borated tag, an ample gauze dressing applied and the two knees further immobilized by plaster. This position was well tolerated. Dressing first changed 12 days p. o. As the flap had completely united the pedicle was divided and the plaster bandages removed. Discharged in seven weeks with all wounds completely healed, the transplanted flap then measuring 11x4 ctm. Subsequent observation proved the permanency of the cure.

The second case, in a boy of 5 years and six months, was one of loss of the heel skin from an accident. The last point to heal over was about the posterior end of the calcis. But the scar tissue covering the whole heel ulcerated afresh on slight use. At the end of six months the foot was in equinus position, and presented a three and a half to one and a half ctm. ulcer over the calcis.

Both extremities were flexed at knee and hip—the right more than the left—so that the affected heel lay on the inside of the left calf, and each separately covered with plaster about the knee and adjacent parts of thigh and leg. The two were then immobilized in this position by a third plaster bandage. The heel sore and adjacent cicatrix, to the extent of 4 ctm. sq., was removed, and subcutaneous tenotomy performed to correct the equinus position. The tuber calcanei was now only covered by periosteum. The flap was taken longitudinally from the inside of the left leg, with its pedicle above. It was 8x5 ctm. in extent and included skin and fascia. The length of flap allowed the necessary twisting—nearly to a right angle. It was secured in place by catgut sutures at the anterior upper and lower edges, and covered

with boric ointment. The whole operative field was then well dressed with sublimated gauze. No fever. Permanent dressing removed in six days. The flap having entirely united the pedicle was cut and the plaster removed—probably at the earliest date in any case yet recorded. Within two weeks even the line of severance had healed. Color and temperature normal. Sensation returned rapidly *after* the first four days. The next four weeks he went around in common shoes and the skin took on much the same character as that of the other heel. No recurrence of ulceration.

CASE III. Man of 53. Skin torn from left elbow region by a machine. The defect at first extended 25 ctm. along the back of arm and forearm by 20 ctm. across. As after four and a half months' treatment an open place still remained over the olecranon, a substituting flap was drawn from the left breast and hypochondrium. The patient was placed on the right side. First the sore, with its surrounding very thin cicatrix, in the form of a 10 x 7 ctm. rectangle, was prepared off. The arm, bent at a right angle, was laid on the chest and the desired flap determined. The pedicle fell rather behind the posterior axillary line. The upper flap edge was on a level with the tenth rib; the lower, 10 ctm. below; the front edge in the mammary line, length of flap 13–14 ctm. The forearm, half supine, was brought to a right angle and the arm firmly pressed against the thorax. After adjustment and fixation of the flap and abundant cushioning, the whole was fixed in position with plaster (of Paris) like a Desault dressing. Dressing removed and pedicle divided on ninth day. Later there was a slight border-gangrene along the upper edge, but in five and a half weeks everything had firmly healed over and he could be dismissed. Sensation had returned fairly, yet was not as good as on the other side.

He repeats his former directions for securing union of fresh skin flap; immobilization in most comfortable position by plaster (of Paris). Excision of the ulcer surface. Flap formation in the main direction of the vessels. Fixation of the flap with sublimated catgut sutures. Antiseptic permanent dressing.—*Arch. f. Klin. Chirg.*, 1886, Bd. 33, Hft. ii.

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